LIFT

RCT Paratransit Application

RiverCities TRANSIT

All questions must be answered.

1 Eligibility Questionnaire

This form must be completed by either the applicant or someone authorized to sign on the applicant's behalf.

2 Professional Verification Form

All applicants must sign the Authorization for the Release of Information included on page 6. The rest of the form must be completed a professional who is familiar with the applicant's condition and qualified to respond (right).

3 Submit Both Forms Together

Submit both the BLUE Eligibility Questionnaire and the PURPLE Professional Verification Form together. All applications will be processed within 21 calendar days of receipt of a completed packet and the applicants will be notified in writing of RiverCities Transit determination of eligibility.

List of Qualified Professionsals:

- Physician or Psychiatrist
- Physical Therapist
- Physician Assistant
- Licensed Independent Social Worker (LISW, LICSW)
- Occupational Therapist
- Registered Nurse or Nurse Practitioner
- Psychologist
- Certified Orientation and Mobility Specialist
- Speech/Language Pathologist

RiverCities Lift recognizes that many professionals work with clients that are disabled and the list above is not meant to exclude those professions. In general, this will require completing a multi year degree program and/or being licensed by a public agency such as the WA State Dept of Health.

A primary care physician is often able to adequately complete this form. You do not need to visit a specialist.

Avoid Delays in Application Process

- All pages for both forms must be submitted
- Check that all questions have been answered
- Make sure all needed signatures are present
- Double check the professional credential section is complete

An incomplete application will be returned to the applicant one (1) time with a notice of what is missing. If it is returned to RCT incomplete a second time, the applicant will be sent a new blank application to complete.

In-Person Assessment

The eligibility of most applicants can be determined by the forms submitted to RCT staff. However, there may be cases where RCT requests to conduct an in-person functional assessment of an applicant's disability. This assessment may include, but is not limited to:

- A conversation about the applicant's mobility
- Reading a bus schedule to plan out a future bus trip
- Taking a short walk
- Practice boarding an actual bus

If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided.

1 PART 1 Eligibility Application

Complete the entire application. Incomplete applications will be returned.

Is this a new application, or a recertification? ☐ New ☐ Recertification

Applicant Information

First Name	Last Name		Middle Initial
Street Address			Apartment #
City	State		Zip code
Is this an apartment complex, mobile home park, or facility? ☐ Yes ☐ No	Name of complex or facility		
Home Phone	Mobile Phone	Gender ☐ Male ☐ Female	
Date of Birth (m/d/y)	Primary Language ☐ English ☐ Other ____________		

☐ Check this box if someone other than the applicant is completing this form provide and provide information:

Legal Guardian Information

First Name	Last Name		Middle Initial
Street Address			Apartment #
City	State		Zip code
Home Phone			
Relationship to Applicant (Spouse, Case Worker, etc.)			

In case of emergency, who should we contact?
Emergency Contact Name
Phone
Work Phone
Relationship

Who is authorized to contact RCT on your behalf?
Contact Name 1 (Individual or Organization)
Phone
Contact Name 2 (Individual or Organization)
Phone

A General Information

How long would you like to use the service? Permanently ☐ Temporarily ☐

What is your current primary transportation option?

- ☐ Walking
- ☐ Drive myself
- ☐ Ride with somebody
- ☐ Taxi
- ☐ Fixed Route Bus
- ☐ Bicycle
- ☐ RiverCities LIFT
- ☐ Other, specify:____________________

Can you use the fixed route bus without someone else's help?

- ☐ Yes, I currently ride the Fixed Route Buses.
- ☐ I only ride with assistance from others.
- ☐ I only ride when the bus stops are accessible.
- ☐ No, I have never ridden.
- ☐ I do not ride anymore **because:**____________________

RCT provides free, in-person, training to help you learn to ride our Fixed Route Buses. Interested?

☐ Yes ☐ No ☐ Possibly, please contact me

Do you require a Personal Care Attendant to travel with you?

☐ Yes ☐ No ☐ Sometimes, **specify:**____

Do you use a service animal? ☐ No ☐ Yes, type:____

B Required Assistance

What mobility device(s) will you be using? Larger, heavier, wheelchairs may exceed equipment transport capacity.

- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ White Cane
- ☐ Prosthesis
- ☐ Portable Oxygen
- ☐ Manual Wheelchair
- ☐ Powered Wheelchair/scooter
- ☐ No aid required

What is your estimated bodyweight? ________ **lbs.**

Are you able to complete the following tasks without assistance from another person?
Check a box for each question. If you answer **Sometimes** for any questions please explain.

Task			
A. Get to/from a bus stop?	☐ Always	☐ Never	☐ Sometimes
B. Walk (or travel using a mobility device) 3 blocks?	☐ Always	☐ Never	☐ Sometimes
C. Get on/off a fixed route bus without using the lift or ramp?	☐ Always	☐ Never	☐ Sometimes
D. Get on/off a fixed route bus using the lift or ramp?	☐ Always	☐ Never	☐ Sometimes
E. Climb three 10-inch steps?	☐ Always	☐ Never	☐ Sometimes
F. Wait at a bus stop while standing for 15 minutes?	☐ Always	☐ Never	☐ Sometimes
G. Wait at a bus stop while sitting for 15 minutes?	☐ Always	☐ Never	☐ Sometimes
H. Maintain your balance entering, exiting, and riding a fixed route bus?	☐ Always	☐ Never	☐ Sometimes
I. Understand and follow verbal directions?	☐ Always	☐ Never	☐ Sometimes
J. Recognize correct stops and landmarks to complete a trip?	☐ Always	☐ Never	☐ Sometimes
K. Hear stops announced by the driver?	☐ Always	☐ Never	☐ Sometimes
L. Read and understand informational signs?	☐ Always	☐ Never	☐ Sometimes
M. Plan a trip using the bus schedule?	☐ Always	☐ Never	☐ Sometimes
N. Clearly communicate information about yourself?	☐ Always	☐ Never	☐ Sometimes

Please explain any boxes checked **Sometimes:**____

____

____

____

C Disability Information

These questions help describe your disability and how it may impact you.

What is your disability? ____

Check all that apply

Is your disability:

☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary, **how long?** Months _______ Years _________

Explain how your disability prevents you from the following:

Please provide a complete, and specific, answer. Attach an additional page if needed.

- Getting on or off a lift equipped fixed route bus; and/or
- Getting to or from a bus stop; and/or
- Successfully completing a bus trip.

____
____
____
____
____
____

How far can you travel on level ground? With your mobility aid, if any.

☐ Less than one block ☐ two blocks ☐ three blocks ☐ Four blocks, or more.

With your mobility aid, if any, can you:

Wait at the street curb for a ride?	☐ Yes	☐ No
Wait at the front door/lobby for your ride?	☐ Yes	☐ No

Does your disability change daily in ways that could disrupt your ability to use fixed route bus service?

☐ No ☐ Yes, explain:____
____
____
____
____
____

Please list three trips you frequently take:

Starting Address	Ending Address
1. ____________________	____________________
2. ____________________	____________________
3. ____________________	____________________

D Application Signature

I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that the falsification of information may result in the denial of service. I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct (RCW 9A.72.085). This application will be used to determine Paratransit eligibility under the ADA and may include an in-person functional assessment. Periodic recertification may be required.

____   ______/____/______

Applicant, or Legal Guardian's Signature   Date

Part 1 Completed.

2 PART 2

Professional Verification

Complete the entire application. Incomplete applications will be returned.

Release Information

Medical Information Release / HIPAA Authorization

I ______________________________ authorize the healthcare provider(s), and their office staff, completing this application to release to RiverCities Lift any protected health information about my disability in order to verify my eligibility for Paratransit service. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on this application unless revoked in writing

____ ______/______/______

Print Applicant Name Date

Your Affected Health Providers

Each provider listed below should copy and complete the remaining pages of this application.

Health Care Providers		
Provider 1	Profession	
Address	Phone	Fax
Provider 2	Profession	
Address	Phone	Fax
Provider 3	Profession	
Address	Phone	Fax

The following pages must be filled out by your Health Care Provider.

A General Disability Questions

Describe the diagnosed disability or disabilities that you are currently treating this individual for?

____

____

____

____

____

Check all that apply

Is the patient's disability:

☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary, **how long?** Months _______ Years ___________

Does your client's disability:

☐ Affect mobility ☐ Affect judgment ☐ Require using a mobility aid

☐ Require them to have assistance when traveling outside their residence

Can your client:

A. Walk two blocks (600 feet) with their mobility aid if any?	☐ Yes	☐ No
B. Climb three standard steps without assistance?	☐ Yes	☐ No
C. Stand without support for 15 minutes?	☐ Yes	☐ No
D. Walk or stand without debilitating pain or discomfort?	☐ Yes	☐ No
E. Get on or off a fixed route bus with or without using an ADA wheelchair lift?	☐ Yes	☐ No
F. Recognize correct stops and landmarks to complete a trip?	☐ Yes	☐ No
G. Hear and understand verbal information?	☐ Yes	☐ No
H. Read and understand informational signs?	☐ Yes	☐ No
I. Plan a trip using public transportation?	☐ Yes	☐ No
J. Communicate information about themselves?	☐ Yes	☐ No

B Disability Specific Questions

ICD 9/DSM Code for the condition(s) you are treating? ______________________________

GAF Score (if citing a cognitive or psychological disorder)**:** ______________________________

Please only complete those questions that apply to this applicant for this section.

Does the applicant experience seizures? ☐ No ☐ Yes, frequency and severity: ______________________________

____

____

Does the applicant experience auras? ☐ No ☐ Yes

Is the applicant's judgment impaired? ☐ No ☐ Yes

Does this condition affect the applicant's ability to move independently outside their residence or a supervised environment? ☐ No ☐ Yes

Does the applicant experience any hallucinations, delusions, or disassociation? ☐ No ☐ Yes
And, does this prevent the applicant from being oriented to person, place, & time? ☐ No ☐ Yes

Other : ______________________________

____

Please describe any triggers that may cause psychological disorders to manifest?______________________________

____

____

____

Please describe the functional limitations caused by this impairment? ______________________________

____

____

____

C

Does the applicant have a visual impairment that affects their ability to move about in the environment?

☐ No ☐ Yes, explain: ____________________

Has the applicant received any orientation & mobility training?

☐ No ☐ Yes, explain: ____________________

Please list any side effects of medication the applicant experiences.

Any additional comments on the functional ability of the applicant?

D ## Provider Affirmation

Provider Information		
Address	Phone	Fax
City	State	Zip code
Provider UPIN # or Tax ID	Employer / Agency	

Provider Signature and Affirmation

I am a licensed medical provider or qualified service provider with a state/county agency in the field indicated below and certify that the above mentioned individual has the disability and limitations indicated above. (RCW 9A.72.085 & RCW 40.16.030)

______________________________   ____/____/____

Provider Signature   Date

____

Provider Printed Name

Part 2 Completed.

3 PART 3 Submit Both Forms Together

Make sure all questions have been answered, and required signatures are in place.

Submit both the BLUE Eligibility Questionnaire and the PURPLE Professional Verification Form.

RiverCities Transit
ATTN: Mobility Supervisor
PO Box 128
Longview, WA 98632
Fax #: 360-442-5979

You may also submit all forms in person at the Transit Center
1135 12th Ave
Longview, WA 98632

Hours of operation:
7:30 to 6 M-F, 8-5 Sat

All applications will be processed within 21 calendar days of receipt of a completed packet and the applicants will be notified in writing of RiverCities Transit determination of eligibility.

In-Person Assessment

You will be contacted if an In-Person assessment is required. If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided.

Thank you for completing the Paratransit Application, and making sure all questions have been answered, signatures gathered, and both forms are complete before your application is submitted. We look forward to serving you.

360.442.5663

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www.rctransit.org/LIFT